

Department of Developmental Disabilities

## Medical Expense Tracking

Child's Name:	DOB:
Family Yearly Income:	Out of pocket medical expenses:
IFSP year:	EI Forms 1701, 1702, and 1703 Attached with IFSP $$ Y $\square$ $$ N $\square$

Receipt Number	Date Payment Made	Service Payment was for	Amount of Medical expense	Amount Paid by you	Cumulative amount paid by you

EI 1704 8/1/2017



## Medical Expense Tracking

Receipt	Date Payment	Service Payment was for	Amount of Medical	Amount Paid	Cumulative amount
Number	Made		expense	by you	paid by you

FOR PROGRAM USE ONLY: Out of pocket medical expense met: Yes \_\_\_\_\_ No \_\_\_\_\_ Dept. 's Authorized initials: \_\_\_\_\_